Washington State Department of Labor & Industries
Workers' Compensation Services

Provider Bulletin

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Title: Comprehensive Treatment for Chronic Noncancer Pain

To:
Doctors
Pain Clinics
Hospitals
Nurses ARNP
Vocational Counselors
Self-Insured Employers

From:
Bob Mayer
PO Box 44322
Olympia, WA 98504-4322
Email: mayr235@Lni.wa.gov

Provider Hotline 1-800-848-0811 or from Olympia 902-6500

Affects: ☒ State Fund claims ☒ Self-Insured claims
☒ Crime Victims Compensation Program ☒ All locations

Effective Date: **November 1, 2009** **Removal from Web Date:** **June 30, 2011**

Provider Bulletins are temporary communications to announce changes to rule, law, policy, coverage decision or programs. For access to **updated** and complete information to this rule/coverage decision/policy etc., please visit the 2010 Medical Aid Rules and Fee Schedule (available June 2010):
http://www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/

Coverage Decision

Injured workers eligible for benefits under Title 51 RCW may be evaluated for and enrolled in a comprehensive treatment program for chronic noncancer pain if it meets the definition of a structured, intensive, multidisciplinary program (SIMP). Prior authorization is required for all workers to participate in a SIMP for functional recovery from chronic pain. Special conditions and requirements apply to workers who are considering having a lumbar fusion or lumbar intervertebral artificial disc replacement due to uncomplicated degenerative disc disease (referred to as lumbar surgery candidates as defined in WAC 296-20-12065). *In this policy, these conditions and requirements are noted by an eyeglass symbol:* 👓.

Lumbar surgery candidates must successfully complete a SIMP to obtain authorization for a lumbar fusion or a lumbar intervertebral artificial disc replacement.

Goals

The goals for this program are to help workers recover their function, reduce or eliminate disability, and improve the quality of their lives by helping them cope effectively with chronic noncancer pain.

Purpose

The purpose of this bulletin is to explain the revisions the department is making to its policies concerning the treatment of injured workers with chronic pain management issues.

Policy information

Portions of this policy are supported by WAC 296-20-12055 through WAC 296-20-12095.

Definitions

Defined terms throughout this bulletin are noted in *italics*.

The following definitions apply to this policy:

SIMP: means a chronic pain management program with the following four components:

Structured means care is delivered through regular scheduled modules of assessment, education, treatment, and follow up evaluation where workers interact directly with licensed health care practitioners. Workers follow a *treatment plan* designed specifically to meet their needs.

Intensive means the Treatment Phase is delivered on a daily basis, 6-8 hours per day, 5 days per week, for up to 4 consecutive weeks. Slight variations can be allowed if necessary to meet the worker's needs.

Multidisciplinary (interdisciplinary) means that structured care is delivered and directed by licensed health care professionals with expertise in pain management in *at least* the areas of medicine, psychology, and physical therapy or occupational therapy. The SIMP may add vocational, nursing, and additional health services depending on the worker's needs and covered benefits.

Program means an interdisciplinary pain rehabilitation program that provides outcome-focused, coordinated, goal-oriented team services. Care coordination is included within and across each service area. The program benefits workers who have impairments associated with pain that impact their participation in daily activities and their ability to work. This program measures and improves the functioning of persons with pain and encourages their appropriate use of healthcare systems and services.

Uncomplicated Degenerative Disc Disease (UDDD) means chronic low back pain of discogenic origin without objective clinical evidence of any of the following conditions:

- Radiculopathy;
- Functional neurologic deficits;
- Spondylolisthesis (> Grade 1);
- Isthmic spondylolysis;
- Primary neurogenic claudication associated with stenosis;
- Fracture, tumor, infection, inflammatory disease; or
- Degenerative disease associated with significant deformity.

Lumbar surgery candidate means an injured worker who is considering having a lumbar fusion or lumbar intervertebral artificial disc replacement due to uncomplicated degenerative disc disease.

Important Associated Conditions means medical or psychological conditions (often referred to as co-morbid conditions) that hinder functional recovery from chronic pain.

Treatment Plan means an individualized plan of action and care developed by licensed health care professionals that addresses the worker's identified needs and goals. It describes the intensity, duration, frequency, setting, and timeline for treatment and addresses the elements described in the Treatment Phase. It is established during the Evaluation Phase and may be revised during the Treatment Phase.

Valid Tests and Instruments means those that have been shown to be scientifically accurate and reliable for tracking functional progress over time.

Phases of an Approved SIMP

See the Referral and Prior Authorization Requirements section for information about how and when each phase may be prior authorized by the claim manager.

Evaluation Phase

The Evaluation Phase occurs before the Treatment Phase and includes *treatment plan* development and a report. Only one evaluation is allowed per authorization but it can be conducted over 1-2 days. The Evaluation Phase includes all of the following components:

1. A history and physical exam along with a medical evaluation by a physician. Advanced registered nurse practitioners and certified physician assistants can perform those medical portions of the pre-treatment evaluation that are allowed by the Commission on Accreditation of Rehabilitation Facilities (CARF);
2. Review of medical records and reports, including diagnostic tests and previous efforts at pain management;
3. Assessment of any *important associated conditions* that may hinder recovery e.g. opioid dependence and other substance use disorders, smoking, significant mental health disorders, and unmanaged chronic disease. If such conditions exist, see "Referral and Prior Authorization Requirements" section.
4. Assessment of past and current use of all pain management medications, including over the counter, prescription, scheduled, and illicit drugs;
5. Psychological and social assessment by a licensed clinical psychologist using *valid tests and instruments;*
6. Identification of the worker's family and support resources;
7. Identification of the worker's reasons and motivation for participation and improvement;
8. Identification of factors that may affect participation in the program;
9. Assessment of pain and function using *valid tests and instruments*; it should include the current levels, future goals, and the estimated treatment time to achieve them for each of the following areas:
    a. Activities of Daily Living (ADLs)
    b. Range of Motion (ROM)
    c. Strength
    d. Stamina
    e. Capacity for and interest in returning to work
10. If the claim manager has assigned a vocational counselor, the SIMP vocational provider must coordinate with the vocational counselor to assess the likelihood of the worker's ability to return to work and in what capacity (see "Vocational Services" section);

11. A summary report of the evaluation and a preliminary recommended *treatment plan*; if there are any barriers preventing the worker from moving on to the Treatment Phase, the report should explain the circumstances;
12. ☙ For lumbar surgery candidates, the report should address their expectation and interest in having surgery.

Treatment Phase

Treatment Phase services may be provided for up to 20 consecutive days (excluding weekends and holidays) depending on individual needs and progress toward treatment goals. Each treatment day lasts 6-8 hours. Services are coordinated and provided by an interdisciplinary team of physicians, psychologists, physical or occupational therapists, and may include nurses, vocational counselors, and care coordinators. Treatment must include all the following elements:

1. Graded Exercise: Progressive physical activities guided by a physical or occupational therapist that promote flexibility, strength, and endurance to improve function and independence;
2. Cognitive Behavioral Therapy: Individual or group cognitive behavioral therapy with the psychologist, psychiatrist, or psychiatric advanced registered nurse practitioner;
3. Coordination of Health Services: Coordination and communication with the attending provider, claim manager, family, employer, and community resources as needed to accomplish the goals set forth in the *treatment plan;*

   ☙ For lumbar surgery candidates, communication and consultation with the spine surgeon is recommended;
4. Education and skill development on the factors that contribute to pain, responses to pain, and effective pain management;

   ☙ For lumbar surgery candidates, this includes provision and review of a patient education aid, provided by the insurer, describing the risks associated with lumbar fusion;
5. Tracking of Pain and Function: Individual medical assessment of pain and function levels using *valid tests and instruments*;
6. Ongoing assessment of *important associated conditions*, medication tapering, and clinical assessment of progress toward goals; opioid and mental health issues can be treated concomitantly with pain management treatment;
7. Performance of real or simulated work or daily functional tasks;
8. SIMP vocational services may include instruction regarding workers' compensation requirements. Vocational services with return to work goals are needed in accordance with the Return to Work Action Plan when a vocational referral has been made;
9. A discharge care plan for the worker to continue exercises, cognitive and behavioral techniques and other skills learned during the Treatment Phase;

10. A report at the conclusion of the Treatment Phase that addresses all the following questions:
    a. To what extent did the worker meet his or her treatment goals?
    b. What changes if any, have occurred in the worker's medical and psycho-social conditions, including dependence on opioids and other medications?
    c. What changes if any, have occurred in the worker's pain level and functional capacity as measured by *valid tests and instruments*?
    d. What changes if any, have occurred in the worker's ability to manage pain?
    e. What is the status of the worker's readiness to return to work or daily activities?
    f. What is the status of progress in achieving the goals listed in the Return to Work Action Plan if applicable?
    g. How much and what kind of follow up care does the worker need?
    h. ∽ For lumbar surgery candidates, what is the worker's current expectation and interest in having surgery?

Follow up Phase

So long as the claim remains open, a Follow up Phase may occur within 6 months after the Treatment Phase has concluded. This phase is not a substitute for and cannot serve as an extended Treatment Phase. The goals of the Follow up Phase are to:

1. Improve and reinforce the pain management gains made during the Treatment Phase;
2. Help the worker integrate the knowledge and skills gained during the Treatment Phase into his or her job, daily activities, and family and community life;
3. Evaluate the degree of improvement in the worker's condition at regular intervals and produce a written report describing the evaluation results.
4. Address the goals listed in the Return to Work Action Plan if one was developed.

Site of the Follow up Phase

The activities of the Follow up Phase may occur at the original multidisciplinary clinic (clinic based) or at the worker's home, workplace, or health care provider office (community based). This approach permits maximum flexibility for workers whose needs may range from intensive, focused follow up care at the clinic to more independent episodes of care closer to home. It also enables workers to establish relationships with providers in their communities so they have increased access to health care resources.

Face to face vs. Non face to face Services
Follow up services are payable as "face to face" and "non face to face" services. Face to face services are when the provider interacts directly with the worker, the worker's family, employer, or other health care providers. Non face to face services are when the SIMP provider uses the telephone or other electronic media to communicate with the worker, worker's family, employer, or other health care providers for the purpose of coordinating care in the worker's home community. Both are subject to the following limits:

1. Face to face services: up to 24 hours are allowed with a maximum of 4 hours per day.
2. Non face to face services: up to 40 hours are allowed.

Reporting Requirements
If a worker has been receiving follow up services, a summary report must be submitted to the insurer that provides the following information:

1. The worker's status, including whether the worker returned to work, how pain is being managed, medication use, whether the worker is getting services in his or her community, activity levels, and support systems;
2. What was done during the Follow up Phase;
3. What resulted from the follow up care; and
4. Measures of pain and function using *valid tests and instruments*.

This summary report must be submitted at the following intervals:
1. For non lumbar surgery candidates: at 1 and 3 months;
2. For lumbar surgery candidates (regardless of whether they had lumbar surgery after successfully completing SIMP treatment): at 1, 3, *and 6 months*.

The Follow up Phase should include the following kinds of activities according to the worker's identified needs and goals, and may be done either face to face at the clinic or in the community; or as non face to face coordination of community based services:

Evaluation and Assessment Activities during Follow up Phase

1. Assess pain and function with valid tests and instruments.
2. Evaluate whether the worker is complying with his or her home and work program that was developed at the conclusion of the Treatment Phase.
3. Evaluate the worker's dependence, if any, on opioids and other medications for pain.
4. Assess *important associated conditions* and psychological status especially as related to reintegration in the workplace, home and community.
5. Assess what kind of support the worker has in the work place, home, and community.
6. Assess the worker's current activity levels, limitations, mood, and attitude toward functional recovery.

Treatment Activities during Follow up Phase

1. Provide brief treatment by a psychologist, physician, nurse, vocational counselor, or physical or occupational therapist.
2. Adjust the worker's home and work program for management of chronic pain and reactivation of activities of daily living and work.
3. Reinforce goals to improve or maintain progress made during or since the Treatment Phase.
4. Teach new techniques or skills that were not part of the original Treatment Phase.
5. Address the goals listed in the Return to Work Action Plan if one was developed.

Community Care Coordination during Follow up Phase

1. Communicate with the attending provider, surgeon, other providers, the claim manager, insurer assigned vocational counselor, employer, or family and community members to support the worker's continued management of chronic pain.
2. Make recommendations for assistance in the work place, home, or community that will help the worker maintain or improve functional recovery.

Support Activities during Follow up Phase

1. Contact or visit the worker in his or her community to learn about the worker's current status and needs and help him/her find the needed resources.
2. Hold case conferences with the interdisciplinary team of clinicians and/or the worker's attending provider and/or other individuals closely involved with the worker's care and functional recovery.

Special Considerations

When determining what follow up services the worker needs, SIMP providers should consider the following:

1. Meeting with the worker, the worker's family, employer, or other health care providers who are treating the worker is subject to the 24 hour limit on face to face services.
2. If a SIMP provider plans to travel to the worker's community to deliver face to face services, travel time is not included in the 24 hour time limit and the trip must be prior authorized for mileage to be reimbursed.
3. The required follow up evaluations must be done face to face with the worker and are subject to the 24 hour limit on face to face services.
4. When the SIMP provider either meets with treating providers or coordinates services with treating providers, the treating providers bill their services separately.
5. Authorized follow up services can be provided, even if the worker has lumbar surgery during the follow up period.
6. If a SIMP provider wishes to coordinate the delivery of physical or occupational therapy services in the worker's home community, they should be aware that for workers covered by the State Fund, these therapies are often subject to prior authorization and utilization review. For further information, visit: http://www.Lni.wa.gov/ClaimsIns/Providers/Manage/rtw/therapy/default.asp

Policy Requirements

Requirements the SIMP Provider Must Meet

To provide chronic pain management program services to eligible workers, SIMP service providers must meet all the requirements listed in this section. They must:

A. Meet the definition of a Structured Intensive Multidisciplinary Program;
B. Be accredited as an interdisciplinary pain rehabilitation program by the Commission on Accreditation of Rehabilitation Facilities (CARF). Providers must maintain CARF accreditation and provide the Department of Labor & Industries (L&I) with documentation of satisfactory recertification. A provider's account will be inactivated if CARF accreditation expires. It is the provider's responsibility to notify L&I when an accreditation visit is delayed;
C. Provide the services described in each phase;
D. Communicate with providers who are involved with the worker's care;
E. Ensure care is coordinated with the worker's attending provider;
F. Inform the claim manager whether the worker stops services prematurely, has unexpected adverse occurrences, or does not meet the worker requirements;
G. Communicate with the worker during treatment to ensure he or she understands and follows the prescribed treatment;
H. Act as a resource for the worker, insurer, and providers to ensure treatment is progressing as planned and any gaps in care are addressed;
I. Coordinate the worker's transition and reintegration back to his or her home, community, and place of employment.

Requirements the Worker Must Meet

An injured worker must make a good faith effort to participate and comply with the *treatment plan* prescribed for him or her by the SIMP provider. To successfully complete a SIMP, the worker must meet all the requirements in this section. The worker must:

A. Be medically and physically stable enough to safely tolerate and participate in all physical activities and treatments that are part of his or her *treatment plan*;
B. Be psychologically stable enough to understand and follow instructions and to put forth an effort to work toward the goals that are part of his or her *treatment plan*;
C. Agree to be evaluated and comply with treatment prescribed for any *important associated conditions* that hinder progress or recovery (e.g. opioid dependence and other substance use disorders, smoking, significant mental health disorders, and other unmanaged chronic disease);

D. Attend each day and each session that is part of his or her *treatment plan*. Sessions may be made up if, in the opinion of the provider, they do not interfere with the worker's progress toward *treatment plan* goals;

E. Cooperate and comply with his or her *treatment plan*;

F. Not pose a threat or risk to himself or herself, to staff, or to others;

G. Review and sign a participation agreement with the provider;

H. Participate with coordination efforts at the end of the Treatment Phase to help him or her transition back to his or her home, community, and workplace.

Referral and Prior Authorization Requirements

A. All SIMP services require:
   1. Prior authorization by the claim manager; and
   2. A referral from the worker's attending provider.

   An occupational nurse consultant, claim manager, or insurer assigned vocational counselor may recommend a SIMP for the worker, but this cannot substitute for a referral from the attending provider.

B. When the attending provider refers a worker to a chronic pain management program (SIMP), the claim manager may authorize an evaluation if the worker has had unresolved chronic pain for longer than 3 months despite conservative care and has one or more of the following conditions:
   1. Is unable to return to work due to the chronic pain;
   2. Has returned to work but needs help with chronic pain management;
   3. Has significant pain medication dependence, tolerance, abuse, or addiction;
   4. Is a lumbar surgery candidate. It is recommended that lumbar surgery candidates be evaluated by a SIMP prior to requesting the surgery.

C. Prior authorization for the Evaluation Phase occurs first and includes only one evaluation. Once authorized, the SIMP provider verifies the worker meets the requirements set forth in the "Requirements the Worker Must Meet" section, and can fully participate in the program. If the worker:
   1. Meets the requirements and the SIMP provider recommends the worker move on to the Treatment Phase, the SIMP provider must provide the insurer with a report and treatment plan as described under the Evaluation Phase.
   2. Does not meet the requirements, the SIMP provider must provide the insurer with a report explaining what requirements are not met and the goals the worker must meet before he or she can return and participate in the program. If the worker is found to have important associated conditions during the Evaluation Phase that prevent him or her from participating in the Treatment Phase, the SIMP provider must either treat the worker or recommend to the worker's attending provider and the claim manager what type of treatment the worker needs.

D. The Treatment Phase must be prior authorized separately from the Evaluation Phase. Treatment Phase authorization includes authorization for the Follow up Phase.

E. SIMP services are authorized on an individual basis. If there are extenuating circumstances that warrant additional treatment or a restart of the program, providers must submit this request along with supporting documentation to the claim manager.

F. ✍ If a lumbar surgery candidate previously participated in a SIMP as a lumbar surgery candidate but did not successfully complete treatment, one additional SIMP may be authorized only if:
    1. The worker obtains an additional surgical recommendation noting clinical changes one year or more after the date first referred to a SIMP; *or*
    2. The reason the worker did not participate fully or successfully complete a SIMP the first time was because of *important associated conditions* that are now fully resolved.

G. ✍ If a lumbar surgery candidate successfully completed a SIMP and did not have the surgery, and in the future becomes a lumbar surgery candidate again, another SIMP may be authorized, but is not required.

H. If a worker's treatment is interrupted due to significant family or life circumstances such as a death in the family, the claim manager may authorize resuming or restarting the SIMP if recommended by the SIMP provider.

I. If a SIMP provider plans to travel to the worker's community to deliver face to face services, mileage may be reimbursed, but only if it is prior authorized. Lodging and meals (per diem expenses) are not reimbursable. Actual travel time is not included in the 24 hour limit. When requesting prior authorization for mileage, the SIMP provider must explain the reason for the visit and how it will benefit the worker.

Vocational Services

Vocational Referrals

The claim manager will determine, based on the facts of each case, whether to make a vocational referral prior to authorizing participation in a SIMP. The claim manager may assign a vocational counselor if the worker needs assistance in returning to work or becoming employable. The claim manager will not make a vocational referral when the worker:

1. Is working.
2. Is scheduled to return to work.
3. Has been found employable or not likely to benefit from vocational services.

Return to Work Action Plan

A Return to Work Action Plan is required when vocational services are needed in conjunction with SIMP treatment and the claim manager assigns a vocational counselor.

The Return to Work Action Plan provides the focus for vocational services during a worker's participation in a chronic pain management program. The Return to Work Action Plan may be modified or adjusted during the Treatment or Follow up Phase as needed.

At the end of the program, the outcomes listed in the Return to Work Action Plan must be included with the Treatment Phase summary report. If a vocational counselor is assigned, he or she will work with the SIMP vocational counselor to agree upon a Return to Work Action Plan with a return to work goal.

Return to Work Action Plan Roles and Responsibilities

In the development and implementation of the Return to Work Action Plan, the insurer assigned vocational counselor, the SIMP vocational counselor, the attending provider, and the worker are involved. Their specific roles and responsibilities are listed below.

1. The SIMP Vocational Counselor:
    a. Co-develops the Return to Work Action Plan with the insurer assigned vocational counselor;
    b. Presents the Return to Work Action Plan to the claim manager at the completion of the Evaluation Phase if the SIMP recommends the worker move on to the Treatment Phase and needs assistance with a return to work goal;
    c. Communicates with the insurer assigned vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan.
2. The insurer assigned vocational counselor:
    a. Co-develops the Return to Work Action Plan with the SIMP vocational counselor
    b. Attends the chronic pain management program discharge conference and other conferences as needed either in person or by phone
    c. Negotiates with the attending provider when the initial Return to Work Action Plan is not approved in order to resolve the attending provider's concerns
    d. Obtains the worker's signature on the Return to Work Action Plan
    e. Communicates with the SIMP vocational counselor during the Treatment and Follow up Phases to resolve any problems in implementing the Return to Work Action Plan
    f. Implements the Return to Work Action Plan following the conclusion of the Treatment Phase
3. The attending provider:
    a. Reviews and approves/disapproves the initial Return to Work Action Plan within 15 days of receipt

b. Reviews and signs the final Return to Work Action Plan at the conclusion of the Treatment Phase within 15 days of receipt
c. Communicates with the insurer assigned vocational counselor during the Treatment and Follow up Phases to resolve any issues affecting the return to work goal

4. The worker:
   a. Will participate in the selection of a return to work goal
   b. Will review and sign the final Return to Work Action Plan
   c. Will cooperate with all reasonable requests in developing and implementing the Return to Work Action Plan. Should the worker fail to be cooperative, the sanctions as set out in RCW 51.32.110 shall be applied.

Billing Rules

SIMP Fee Schedule

The fee schedule and procedure codes for these phases are listed in the following table. The fee schedule applies to injured workers only in an outpatient program. These outpatient chronic pain management programs must bill using the local codes listed in the following table on a CMS-1500 form.

Description	Local Code	Duration / Limits	Fee Schedule
SIMP Evaluation Services	2010M	One evaluation per authorization, which may be conducted over 1-2 days	$1,106.63
SIMP Treatment Services, each 6-8 hour day	2011M	Not to exceed 20 treatment days (6-8 hours per day)	$708.82 per day
SIMP Follow up Services: Face-to-face services with the worker, the worker's family, employer, or health care providers, either in the clinic or in the worker's community, each hour	2014M (new code)	Not to exceed 4 hours per day and not to exceed 24 hours total	$88.60 per hour
SIMP Follow up Services: Non face-to-face coordination of services with the worker, the worker's family, employer, or health care providers in the worker's community, each hour	2015M (new code)	Not to exceed 40 hours	$70.20 per hour
Mileage for traveling to and from the worker's community.	0392R	Mileage requires a separate prior authorization. Travel time is not included in the 24 hours allotted for face-to-face services.	Current Washington State mileage rate

Billing For Partial Days in the Evaluation and Treatment Phases

Clinics can bill only for that percent of an 8 hour day that has been provided, (even if the patient was scheduled for less than 8 hours). Examples:

1. Only one evaluation is payable. If half the evaluation is completed on day one and half is completed on day two, the clinic would bill half of the evaluation rate ($1106.63 x 50% = $553.32) on each day.
2. The worker has an unforeseen emergency and has to leave the clinic after 2 hours (25% of the treatment day). The clinic would bill $708.82 x 25% = $177.21.

More Information

For Crime Victims

• **Phone:** (800) 762-3716 (toll free)
• **Fax:** (360) 902-5333
Additional information is available at: www.CrimeVictims.Lni.wa.gov

For Self-Insured Claims

Contact the self-insured employer (SIE) or their third party administrator (TPA) to request authorization. For a list of SIE/TPAs, go to:

http://www.Lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/FindEmps/Default.asp

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